REQUEST FOR ARCHIVED RECORDS FOR GENEALOGY PURPOSES

Make all requests for records to:

Montana State Hospital
Attn: Health Information Department
PO Box 300
Warm Springs, MT 59756

The request must be in writing by letter, or e-mail. Requests should include the following:

- Full name including the maiden name and any other names the patient may have been known by
- The dates of birth, and death (when available), and the approximate time the person may have been at Montana State Hospital is helpful
- Purpose or need for the request
- Relationship to the patient
- Date of request
- The attached request for archived records form may also be used

MONTANA STATE HOSPITAL

REQUEST FOR RELEASE OF CONFIDENTIAL ARCHIVED RECORDS

_____
(Name of Patient including maiden and any other known names)

(D.O.B)_____ (D.O.D)_____

Dates inpatient at Montana State Hospital_____

I, _____ _____
(Person requesting records) (Relationship to patient)

_____ (___)_____
(Address) (Phone Number)

Request the following records from Montana State Hospital:_____

_____

_____

_____
(specify extent/nature of information to be disclosed).

The purpose or need for this disclosure is _____

_____

I understand records are protected under Federal Confidentiality Regulations and cannot be disclosed without the written consent of the patient/patient guardian or when neither applicable, the nearest next of kin unless otherwise provided for in the regulations.

Executed this _____ day of _____, 20_____

_____
Signature